08/20/2028 21:33 3018536756	CHRYSALLIS INC	PAGE 01
DEPARTMENT OF HEALTH AND HUMAN SERVICES		PRINTED: 06/25
CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPRO
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUBDITION	(X2) MULTIPLE CONSTRUCTION	<u></u>
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		{(X3) DATE SURVEY
	A. BUILDING	COMPLETED
09G161	8 WING	R
		06/16/2008
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP C	005
CHRYSALLIS	3765 FIRST STREET, SE	ODE
	WASHINGTON, DC 20020	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED by FILL)	PREFIX (EACH CORRECTIVE ACTION	RRECTION (X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG : CROSS-REFERÊNCED TO THE	N SHOULD BE COMPLE E APPROPRIATE DATE
	DEFICIENCY)	:
W 000) INITIAL COMMENTS	044.6-11	
THE COMMENTS	{W 000}	•
A follow-up was conducted on 6/16/2008 to	!	
assess the facility 's level of compliance with the	√ / * 0	· 17
Re-Certification survey completed on May 2	Received	312107
2008. A random sample of three clients was	1 (2001-00	0(0)(0)
selected from a residential population of six	GOVERNMENT OF THE D	ISTRICT OF COLUMBIA
males with mental refardation and other	DEPARIMENT	OF HEALTH
disabilities. The survey findings were based on	HEALTH REGULATION	VADMINISTRATION
observations in the group home, interviews with	825 NORTH CAPITOL S	T., N.E., 2ND FLOOR
the facility staff and a review of records, including	WASHINGTON	, D.C. 20002
unusual incident reports,		
		ı
The findings of the revisit revealed the facility still		
had not met the standards for full compliance with		
the Conditions of Participation in Governing Body,		
Client Protections, and Facility Staffing.		
/ 11/1 100 110/-1/11 OUI-U-	(W 114)	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(VV 114)	
Any individual who makes an entry in a client's	·	
record must make it legibly, date it, and sign it.	As answer to W 114, the f	acility says
a to the Start of the Sign it.	as follows:	
	·	
This STANDARD is not met as evidenced by:	The facility has made a	~ ~
Based on interview and record review, the facility	and created a new	y Quality
failed to ensure that each entry into a client's	Enhancement Review	Tool to
record was signed and dated, for one of three	facilitate detection and co	
clients (Client #1) included in the sample.		
The sample.	any wrong entry in the me	
The finding includes:	of all the residents of the f	
	The quality enhanceme	nt review ongoing
The facility was previously cited during the	form and the new p	
5/2/2008 survey for failing to ensure that its	-	owel are
medical staff/concultants size at any design	attached.	
medical staff/consultants signed and dated each	1	
entry that was made into a client 's medical	·	
record. The example provided was based off of	•	•
Client #1's April 2008 Physician's Orders (POS).		!
The citation reflected that an order for	1	:
Erythromycin Ophthalmology 5mg/gm cintment	:	
which was to be applied to each eye every	•	
ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATU	10F	
TORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE TITLE	(X6) DATE

they deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that they safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 asys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

		AND HUMAN SERVICES			FOR	06/25/2008 APPROVED
		& MEDICAID SERVICES	· ,		OMB NO	0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION :	(X3) DATE COMPL	SURVEY
	· .	09G161	B. Wir	NG	. 06/	R 1 6/2008
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
CHRYS	ALLIS			3765 FIRST STREET, SE WASHINGTON, DC 20020		,
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	מו	PROVIDER'S PLAN OF CO	DEPECTION	
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X ' (EACH CORRECTIVE ACTIO	N SHOULD BE E APPROPRIATE	COMPLETION DATE
{W 000}	INITIAL COMMENT	'S	{W 0	00}		
	assess the facility 's Re-Certification survival 2008. A random sall selected from a resimales with mental redisabilities. The surposervations in the gibbe the facility staff and unusual incident reput The findings of the rehad not met the stanthe Conditions of Pa Client Protections, as	vey findings were based on group home, interviews with a review of records, including orts. evisit revealed the facility still dards for full compliance with rticipation in Governing Body, and Facility Staffing.		GOVERNMENT OF THE I DEPARTMEN HEALTH REGULATIO 825 NORTH CAPITOL WASHINGTO	T OF HEALTH)N ADMINISTRATI ST., N.E., 2ND FI (IONI
	483.410(c)(4) CLIEN Any individual who m record must make it	T RECORDS nakes an entry in a client's legibly, date it, and sign it.	{VV 11	As answer to W 114, the	facility says	
	Based on interview a failed to ensure that of	not met as evidenced by: nd record review, the facility each entry into a client's nd dated, for one of three luded in the sample.		Enhancement Review facilitate detection and coany wrong entry in the m	W Quality Tool to orrection of nedical book	
	The finding includes:			of all the residents of the The quality enhancement	•	8/18/08 ongoing
: : (: (: - : - : :	5/2/2008 survey for famedical staff/consultate entry that was made record. The example Client #1's April 2008 The citation reflected Erythromycin Ophtha	ously cited during the ailing to ensure that its ants signed and dated each into a client 's medical provided was based off of Physician's Orders (POS). Ithat an order for Imology 5mg/gm ointment ed to each eye every		form and the new attached.	policy are	
ORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	· · · · · ·	X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2008 FORM APPROVED OMB NO. 0938, 0301

CENTE	KS FOR MEDICARE	& MEDICAID SERVICES	<u> </u>			OMB N	<u>0. 0938</u> -039
		(X1) 'PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	MULTIP	PLE CONSTRUCTION	(X3) DATE	SURVEY LETED
		<u>.</u>	B. WI	ING			R
	- <u>-</u>	09G161	B. VVI			06	/16/2008
	CHRYSALLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 114) Continued From page 1 evening was discontinued and there was no corresponding signature or date to validate that order. The facility's plan of correction detailed that by 6/10/2008 this deficient practice would be addressed by the following action(s): "The nurse had been instructed to review all physician orders for proper signature and dating				STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE		
Onk 107					ASHINGTON, DC 20020		
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
(W 114)	Continued From pa	ge 1	· {W 1	1143			
	evening was discor	tinued and there was no	; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	' ' ' ' <u>'</u> '.			
		ature or date to validate triat	!				;
	: The facility's plan	of correction detailed that by	; ·	<u>i</u>	•		i
	6/10/2008 this defic	ient practice would be					
	addressed by the fo	flowing action(s):	i				
			ī	•			•
	physician orders for	proper signature and dating.					
,	the MD makes on the	and date every notation that ne physician orders and in the					
	medical records. The	ne DON will more					
		r entries in clients' records to		i			
		ompliance with recording					
	procedures. "						
	O= 0/40/0000			•			
	Written order for Del	d review revealed a hand prox 6.5% solution was					
		3 's medical records in May					
		her signed nor dated. In					
		lear who ordered this new					
	medication. Further	record review revealed, a					
		to discontinue Aurodex ear					
		in the 3/2008 Physician		i			
:	Order Sheets. Acco	rding to the QMRP as		i			
1	discontinued and wa	2008, the Aurodex was is to be replaced by the					
	Debrox 6.5% solution	n. From the records		1			
		ening of 6/16/2008, it was	•	1			
		nedication started or was	•				
	stopped. It was also			:			1
		at these medications were to					}
, !	be exchanged and/o	r initiated for treatment as the			·		}
		were missing. The facility ffective system to address		1 .			i .
		g and dating of entries into a		_			:
; (client 's medical reco	ords as previously cited on		1			
1.	5/2/2008	in the proviously offer of		:			

DEPAR CENTE	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES			FUKIV): 06/25/2008 1 APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	MULTIPLE CONSTRUCTION	(X3) DATE S	0.0938-0391 BURVEY ETED
		09G161	B. WI	NG	I	R
NAME OF	PROVIDER OR SUPPLIER					6/2008
CHRYS				STREET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION)	ID PREF TAC	1	HOULD BE	(X5) COMPLETION DATE
{W 124}	483.420(a)(2) PROT	ECTION OF CLIENTS	{W 1	24}		
	I herefore the facility parent (if the client is of the client's medical and behavioral statuments)	sure the rights of all clients. must inform each client, s a minor), or legal guardian, al condition, developmental us, attendant risks of e right to refuse treatment.		The facility has new conse for psychotropic medica treatment for the residen facility. The two forms are a	tion and ts of the attached.	6/16/08
:	This STANDARD is Based on interview a failed to ensure their their legal guardian to medical condition, destatus, attendant risk to refuse treatment, f	not met as evidenced by: nd record review, the facility ights of each client and/or be informed of the client's velopmental and behavioral s of treatment, and the right or two of the three clients cluded in the sample.		The DON and QMRP will conthe process and ensure needed consent is obtained use of psychotropic medical treatment.	that all. d for the	ongoing
	The finding includes:			•		
: (ensure client 's guard	ously cited for failing to dians were informed of ations, and for failing to ent prior to initiating a on regimen.				
t ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	that by 6/18/2008 they mplement an "informaddress this systemic 5:12pm, the facility's Retardation Profession peen created and that going forward. Record evidence on file or survey to substantiate	ned consent " form to void. On 6/16/2008 at Qualified Mental nal indicated the form had the facility plans on using it dreview revealed there was presented at the time of that such a form was			:	
t i e f E g n s	obtain informed consepsychotropic medications and the facility presented that by 6/18/2008 they implement an "informed dress this systemic 5:12pm, the facility's Retardation Profession open created and that going forward. Record evidence on file or survey to substantiate	in their plan of correction would create and ned consent " form to void. On 6/16/2008 at Qualified Mental nal indicated the form had the facility plans on using it direview revealed there was				

		AND HUMAN SERVICES & MEDICAID SERVICES			. FOR	D: 06/25/2008 MAPPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION JILDING	(X3) DATE	0.0938-0391 SURVEY LETED
		09G161	B. WI	NG	06	R 16/2008
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		10/2008
CHRYS	ALLIS		. •	3765 FIRST STREET, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
{W 124	Continued From page	је 3	; {W 1	24}		
{W 159}	address client safet	IED MENTAL	{W 1			
	integrated, coordina	creatment program must be ted and monitored by a rdation professional.	;	As response to W 159 says as follows: 1. The QMRP shall medical and other book	review the	
	Based on interview a failed to ensure that program was integra	not met as evidenced by: and record review, the facility each client's active treatment ted, coordinated and alified Mental Retardation).		least every two month the outcome of such r the DON and CEO for correction within three reviews. 2. The QMRP shall foll	ns and share reviews with any needed days of such	8/18/08 ongoing
	The findings include:			corrective actions within the review.	in 5 days of	ougoing
	1. The QMRP failed keeping. [See W114	d to ensure accurate record				
		to ensure the review of systems that and safety. [See #124]				
; W 322}	of services to ensure	to ensure the coordination the health and well-being of ts. [See W322, W331] CIAN SERVICES	{W 32	22}		
	The facility must provigeneral medical care	ride or obtain preventive and .				
				1		
	This STANDARD is	not met as evidenced by:				

DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FURI	D: 06/25/2008 MAPPROVED	
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
	· 	09G161	B. WI	NG	OCA	R	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		16/2008	
CHRYS	SALLIS			3765 FIRST STREET, SE WASHINGTON, DC 20020	ODE		
(X4) ID PREFIX TAG	: □ (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N \$HOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{W 322	Continued From page	je 4	{W 3	221		·	
	Based on interview failed to ensure gen services, for two of and #2) included in The findings include	and record review, the facility eral and preventative care he three clients (Clients #1 the sample.	(110	1. Nursing shall inforwithin 3 days after a attempts at collecting borstool specimens for the physician has order	insuccessful oddily fluids test that the ered. The	6/18/08	
	5/2/2008 recertification Client #1 received the directed by the client (PCP); for failing to eantibiotic treatment is failure to ensure Clie of Erythromycin Oint The facility 's plan of 6/4/2008, the facility trained to address the and record review with Mental Retardation F6:05pm revealed the available at the home revisit. In addition, the evidence of the training Nursing and not in his evidence on file or protosubstantiate that a training had been importations levied during 5/2/2008. 483.460(c) NURSING The facility must provise in accordance.	ide clients with nursing ee with their needs.	{W 33	monitor the administra topical ointments a medications to ensure compliance with order.	/she deems . alternative obtaining office, or, ed need for s have been at client #1 the facility and other manner as ig physician. QMRP will iggressively ition of all ind other	6/13/08 ongoing	
	Based on staff intervi	not met as evidenced by: ew and record review, the			·		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2008. FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDE AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	XSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING	NG	ľ	Ŕ	
		09G161	D. VVING		06/1	16/2008	
CHRYSA	PROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 3765 FIRST STREET, SE WASHINGTON, DC 20020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
	The findings included to the facility was previously a client with presented in their has ensure its nursing peradministered/monitor and for failing to ensure its nursing peradministered/monitor and for failing to ensure its nursing peradministered/monitor and for failing to ensure its nursing peradministered in the facility is plan to 6/13/2008 all staff we instructed to consists Client #1 whenever if the day. In addition, the use of sunscreensure is a consistent of the time in the facility is plan to 6/13/2008 all staff we instructed to consists Client #1 whenever in the day. In addition, the use of sunscreensure is the time interview with the facility is deficient pradictly with the facility with the facility is a client profession of the home, but was better the finding the profession of the home, but was better the finding the profession of the home, but was better the finding the first profession of the home, but was better the finding the first profession of the home, but was better the first profession of the home, but was better the first profession of the home, but was better the first profession of the home, but was better the first profession of the home.	nursing services in ir needs, for four of the six hat resided in the facility. riously cited during the on survey for failing to sunscreen lotion as ibilitation plan; failing to ersonnel red each client's treatments; ure the implementation of an documenting discontinued	s e i a a	1	ne nurse. ning on done on ng sheet ill more staff	6/16/08 ongoing	
; - ! ! t	reflects that the facilite effective system of over	presented during the revisit y had failed to implement an versight and care to ensure of its residents. [Cross			:		
			İ	·	• •		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	ING	(X3) DATE SURVEY. COMPLETED R			
	·	HFD03-0229		B. WING	 	06/	16/2008
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	•	
CHRYS	ALLIS			ST STREET STON, DC			•
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETE DATE
{ 000]	INITIAL COMMENT	S		{ 000}			:
	A follow-up was con assess the facility 's Re-Certification survented 2008. A random sa selected from a resi	ey completed on Ma mple of three resider	with the lay 2, and say 2, and say 3				
	males with mental redisabilities. The sur observations in the game the facility staff and unusual incident rep	etardation and other vey findings were ba group home, intervie a review of records,	ised on ws with				1
,	The findings of the rehas not met the stanthe Conditions of Pa Resident Protections	dards for full complication in Govern	ance with ing Body				
{ 180}	3508.1 ADMINISTRA	ATIVE SUPPORT	,	{ 180}			
:	Each GHMRP shall padministrative supponeeds of the resident Habilitation plans. This Statute is not make the statute of the s	rt to efficiently meet ts as required by the net as evidenced by:	eir :		As response to 1180, the facilit as follows: 1. The QMRP shall review medical and other books of recleast every two months are least every two months.	v the	:
	Based on interview a GHMRP failed to ens support had been proneeds of the resident habilitation plans.	sure adequate admir	nistrative ·	,	least every two months and the outcome of such reviews the DON and CEO for any necession within three days of reviews.	with eeded f such	8/18/08 ongoing
:	The finding includes:			:	The QMRP shall follow up corrective actions within 5 days	with	
. ; . ; i (The facility failed to e Mental Retardation Padequately monitored coordinated each resprogram. [See Feder Citation W159]	rofessional (QMRP) f, integrated, and ident's active treatm	ent		J duys		:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MUL1 A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED		
	HFD03-0229		B. WING_		06/	R 16/2008		
NAME OF PROVIDER OR SUPPLIER				STATE, ZIP CODE		1412000		
CHRYSALLIS		3765 FIR: WASHING	ST STREET GTON, DC 2	, SE 20020				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE		
{I 291} Continued From pa	ge 1		{I 291}		····			
{I 291} 3514.2 RESIDENT	RECORDS		{ 291}					
signed by each indiv	e kept current, dated vidual who makes an	entry.						
Based on interview failed to ensure that record was signed a	met as evidenced by: and record review, th each entry into a res and dated, for one of #1) included in the sa	e facility sident's three						
The finding includes	:							
5/2/2008 survey for medical staff/consulentry that was made record. The example Resident #1's April 2 (POS). The citation	inued and there was	its ed each edical d off of ers er for otment y no						
The facility 's plan of 6/10/2008 this deficie addressed by the following the followin	ent practice would be	hat by						
"The nurse has been physician orders for particle MD must sign are the MD makes on the medical records. The aggressively monitor to ensure consistent of procedures."	proper signature and nd date every notation e physician orders an e DON will more entries in residents' r	dating. n that d in the			; ;			
On 6/16/2008, record	review revealed a ha	and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		N	(X3) DATE S	ETED	
	HFD03-0229		B. WING	<u> </u>	bo.	06/16/2008		
NAME OF PROVIDER OR SUPPLIER	·	STREET ADD	RESS, CITY,	STATE, ZIP CODE			.0.2008	
CHRYSALLIS		3765 FIRS WASHING			•			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{I 291} Continued From page	ge 2		{I 291}					
written order for Del entered into Reside May 2008, but it was addition, it is not cle	brox 6.5% solution want #3 's medical recis neither signed nor ar who ordered this in record review reveal to discontinue Aurod in the 3/2008 Physiording to the QMRP a/2008, the Aurodex vas to be replaced by the Common the records ening of 6/16/2008, in medication started or inclear who ordered/ins were to be exchalled a the signal sing. The facility fails system to address the didating of entries in records as previously	ras ords in dated. In new aled, a dex ear dian as vas the s it is r was validated nged atures ed to e nto a y cited on	1 3 0 1 f	The facility hand created Enhancement acilitate detectory wrong entited fall the resident of all the quality of	77.77	v policy Quality ool to ction of al book	8/18/08 ongoing	
{ 401}: 3520.3 PROFESSIO PROVISIONS	N SERVICES: GEN	ERAL {	I 401}					
Professional services and evaluation, included developmental levels services, and services deterioration or further resident.	ding identification of and needs, treatmes s designed to preve	ent nt						
This Statute is not me Based on interview a failed to ensure gene services, for one of the (Residents #1) include	nd record review, the ral and preventative ne three residents	e facility						
The findings include:		i		•				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILD		(X3) DATE COMPI	LETED	
	HFD03-0229		B. WING		R 06/16/2008		
NAME OF PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	<u>. </u>		
CHRYSALLIS			ST STREET STON, DC				
PREFIX (EACH DEFICIENC)	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMP		
5/2/2008 recertifical ensure Client #1 received his antibior manner; and for fail received his treatment in a timely manner. correction detailed to medical staff would above citations. Into the facility 's Qualification of the evidence of train home during the time the QMRP indicated was with the Director possession. Therefore presented at the time that an effective system implemented to add during the recertification of the GHMRP resident that the rights of respondented in accordance.	viously cited during the tion survey for failing ceived the prescribed the client's Primary or failing to ensure Client failing to ensure Client for the facility is plan of t	to d stool Care ent #1 ely #1 Dintment of facility 's s the view with on vealed e at the ddition, trainings in his file or antiate had been ied 008. W322]		1. Nursing shall inform the within 3 days after unsure attempts at collecting bodily or stool specimens for test to physician has ordered. Physician shall address attemptimely manner as he /she medially appropriate (i.e. altemethod of collection, obspecimen himself in office determining the continued not the test.) 2. The medication nurses have instructed to ensure that clicated and other residents of the receive their ointments and medications in a timely man ordered by the prescribing phase. The DON and the QMR henceforth more aggressmonitor the administration topical ointments and	y fluids that the The the that in a deems trinative otaining ce, or, eed for we been ient #1 facility d other othe	6/18/08 6/13/08 ongoing	
This Statute is not n Based on observatio review, the GHMRP protections of each o	n, interview and reco failed to ensure the		. •				

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CTATEME.	NT OF BEEIGIES:			Τ' -		Т	<u>-</u>
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	ETED
		HFD03-0229		B. WING		R	
NAME OF I	PROVIDER OR SUPPLIER	11-003-0229	STREET ADD	T ADDRESS, CITY, STATE, ZIP CODE			6/2008
	•				•		•
CHRYSA	ALLIS		3765 FIRS WASHING	TON. DC	20020		
(X4) ID	SHAMADY STA	TEMENT OF DEFICIENCIE					
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FID1 i	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	ION IORE	(X5)
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMA	ATION)	TAG	CROSS-REFERENCED TO THE APPRI DEFICIENCY)	OPRIATE	DATE
{ 500}	Continued From page	ge 4		{I 500}			
		-		,			
	The findings include	·			The facility has never		
					The facility has new consen	t forms	
	[See Federal Deficie	ency Report Citations	s W124]		for psychotropic medication and treatment for the residents of the		6/16/08
				•	facility The two faces	of the	;
					facility. The two forms are att	ached.	
1			. !		The DON and OMBR - W	11	
,			•		The DON and QMRP will coo	rdinate	
					the process and ensure t	hat all	omanina
					needed consent is obtained	for the	ongoing
			;		use of psychotropic medicati	on and	
			1		treatment.		
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